TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Doctors Hospital at Renaissance

Respondent Name
Travelers Indemnity Co of Connecticut

MFDR Tracking Number
M4-17-1732-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
February 07, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is a formal request for reconsideration of payment for services render to above referenced patient.

According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount.

After reviewing the account we have concluded that reimbursement received was inaccurate."

Amount in Dispute: $466.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has reviewed the billing edits for these procedures, and determined that CPT codes 88307 and 93005 are included with CPT code 27328 for reimbursement Consequently, separate reimbursement is not due for this procedure."

Response Submitted by: Travelers PO BOX 163201 Austin TX 78716

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 13, 2016 through September 15, 2016	Outpatient Hospital Services	$466.68	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - P12 – Workers' Compensation jurisdictional fee schedule adjustment
   - 243 – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed
   - W3 – Additional payment made on appeal/reconsideration
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
   - 1115 – We find the original review to be accurate and are unable to recommend any additional allowance

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to additional reimbursement?

Findings

1. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.

2. This dispute relates to outpatient hospital facility services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.

3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules, which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

   - Procedure code 88307 has status indicator Q2 denoting T-packaged codes; reimbursement for these services is packaged into the payment for any other procedure with status indicator T. This code may be separately payable only if no other such procedures are billed for the same date.

   - Procedure code 93005, service date September 13, 2016, has status indicator Q1 denoting STVX-packaged codes; reimbursement for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X billed on the same claim. This code may be separately payable only if no other such procedures are billed the same day.

4. The total allowable reimbursement for the services in dispute is $2,487.26. This amount less the total paid by the insurance carrier of $2,487.26 leaves an amount due to the requestor of $0.00. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		3/10/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.